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TITLE: Soy and Tamoxifen for Breast Cancer Prevention in High Risk Pre-Menopausal Women

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13. ABSTRACT ***(Maximum 200 Words)***

The current study will test the feasibility and preliminary efficacy of soy supplementation to decrease risk of breast cancer by reducing breast density in individuals with >50% breast density on mammography and who are at elevated risk for breast cancer. Tamoxifen, the only prophylactic agent known to be effective for breast cancer, will be used as a positive control to validate the use of the proposed surrogate markers including breast density. A randomized placebo controlled design will allow for comparative toxicity and efficacy determinations using patients symptoms scores and validated quality of life tools. Biological endpoints of mammographic breast density, breast cytology, urinary estrogen metabolites, and blood serum biomarkers (IGF-1/IGF-BP 3) will be validated using tamoxifen compared with placebo. The magnitude of the soy effect on the same markers will then be compared with that of tamoxifen. Feasibility will be assessed by measuring the rate of recruitment, the percentage of women consuming at least 80% of the expected number of protein packets, and the dropout rate. Initial participant screening has just begun and clinic visits are expected to start in October 2002. At this date there is no data or results to report.

14. SUBJECT TERMS
soy isoflavones, breast cancer prevention, mammographic breast density, quality of life

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57

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Table of Contents

Introduction

The PREVENT study is testing the feasibility and preliminary efficacy of soy supplementation to decrease risk of breast cancer in women with >50% breast density on mammography who are at elevated risk for breast cancer using the Gail model. Tamoxifen, the only prophylactic agent known to be effective for breast cancer, is being used as a positive control to validate the use of the proposed surrogate markers including change in breast density. The randomized placebo controlled design allows for comparative toxicity and efficacy determinations using patient symptom scores, validated quality of life tools, and adverse event profiles. Biological endpoints including changes in mammographic breast density, breast cytology, urinary estrogen metabolites, and blood serum biomarkers (IGF-1/IGF-BP 3, hormone levels) are being validated using tamoxifen compared with placebo.

Accomplishments, Challenges and Future Goals

The framework for successful completion of the study has been put into place in the last year. Forms for collecting data related to all aspects of the study have been designed, tested, and printed (appendix A). A computerized system with optical character recognition has been set up to facilitate data entry and validation. A software data verification system with extensive edits for range checks, missing data, and logical inconsistencies have also been designed and tested. Standard operating procedures have been established for the involvement of numerous working groups at UCSF such as the Breast Care Center (BCC), mammography, radiology, phlebotomy and research lab staff. As recently as one month ago, the final approval was obtained from the local Clinical Human Research committee (CHR) for the study protocol, informed consent, study brochure, as well as several informational tools (appendix B) that will be provided to participants during the intervention period.

The start of the study has been delayed in the past year due to complications relating to contract negotiations and agreement on details of the study protocol between the multiple agencies involved in the management and support of the project. The establishment of a contract with AstraZeneca, the manufacturer of tamoxifen, was delayed, but mutually agreeable terms were reached and both tamoxifen and identical placebo have been received and packaged by our research pharmacy. The approval of

the study protocol by the DOD required months of correspondence before a version that met the local IRB requirements, as well as the DOD, was achieved. The inclusion of Dual X-Ray Absorpotometry (DXA) measurements in the protocol was approved by the local IRB but was an area of concern for the DOD, which resulted in the approval being delayed a little over 1 month. The wording of the *Treatment and Compensation* clause in the informed consent which the local IRB requires specific wording was not acceptable to the DOD and resulted in an additional delay of a final approval several months. The delays encountered with the DOD Office of Regulatory Compliance and Quality can be attributed partially to the departure of the Human Subject Protection Specialist assigned to our protocol and the lag time before contact was made with the new specialist. At the present time approval from the local IRB has been obtained and we are waiting for the DOD approval to be finalized by the DOD contract specialist.

A relative hands off approach by the study coordinator proved to be ineffective in moving forward the project, which involves several parties with varying interests. These challenges have been overcome by active involvement of a new project manager in facilitating the movement of the project forward. We foresee challenges in patient recruitment in the upcoming year, but plan to overcome them by using a recruitment strategy that includes a combination of community outreach events, involvement of practitioners in related fields and advertising in the local print media. In addition, representatives of the study have attended community outreach events aimed toward the local at risk population. The study is also in the process of coordinating with professionals at San Francisco General Hospital in order to offer study participation to women of varied economic and ethnic backgrounds.

The goals for the future are focused around the implementation of the study and enrolling approximately 75% of our final accrual goal of 200 participants by the end of 2003. In the short term, our goal is to enroll 10 participants by January of 2003. Recruitment will then be expanded in the coming year from the established BCC Prevention program patients to women of the greater San Francisco Bay area and the goal will be to enroll 9 women a month into the trial during the 2003 year.

Preliminary screening of women through the UCSF BCC Prevention program has revealed that the current inclusion/exclusion criteria in relation to the assessment of breast cancer risk will prove to be a challenge in finding enough eligible women. In order to overcome this challenge we plan to expand the inclusion criteria to

women with a family history of breast cancer that includes second-degree relatives, rather than the current model that only includes first-degree relatives. A modification is being prepared and will be submitted to the DOD and local CHR by the end of October 2002.

If accrual goals are not consistently met in the early part of 2003, inclusion criteria will be broadened to include women with at least one cancer free breast. The addition of these women to the study population will require a complex set of modifications to the study protocol. The study coordinator, with the supervision of the primary investigators, will investigate these issues over the next few months in order to be prepared if these modifications are required.

Key Research Accomplishments

- UCSF IRB approval of protocol 11/28/2001
- Development of new software for determining breast density
- Training of a radiologist in use of new procedure for determining breast density
- Validation of breast density analysis procedure using 144 sample images with percentage breast density ranging form 0% to 100%.
- Optimization of breast density analysis procedure for use with a G.E. digital mammography instrument, which will be used for all study mammograms
- Designed, tested and printed forms for data collection related to all aspects of the study (appendix A)
- Establishment of a computerized optical character recognition system for data entry and validation
- Development of standard procedures for the collection of biological specimens, including blood, urine and breast duct fluid
- Development of standard procedures for the transport, labeling and storage of biological specimens
- Establishment of contacts with practitioners outside of the UCSF group for referrals of eligible patients
- Development of informational tools to assist participants in following the approved protocol (appendix B)
- Development of procedures for the storage and dispensation of the study drugs with the research pharmacist, Monica Lee, PharmD.

- Soy protein powder and identical placebo received for Protein Technologies International, packaged and labeled by UCSF Cancer Center research pharmacy
- Tamoxifen and identical placebo received from AstraZeneca, packaged and labeled by UCSF Cancer Center research pharmacy

Reportable Outcomes

There are no reportable outcomes at the time of this report. A description of the activities performed over the last year and plans for the completion of the research goals in the upcoming year can be found in an earlier section of this report

Conclusions

All aspects involved in the implementation of the approved study protocol are in place and will be implemented once final approval is received from the DOD.

Appendix A

Study Forms

Screening ID #	Acrostic	Date of Interview	Staff ID #
		Month / Day / Year	0 0

INITIAL SCREENING INTERVIEW

Participant Status

- O Eligible, screening visit scheduled
- O Eligible, but not interested or refused to schedule screening visit
- O Not eligible
- O Refused to complete screening interview
- O Call back, when? →

Date: ____ / ____ / ____ (Month / Day / Year)

Time: ____ : ____ ○ am ○ pm

1. First I would like to confirm some information about you:

First Name

Last Name

Home Address

Street Address

Apt/Room

City State

Zip Code

Home Telephone: ( ) - (Area Code / Number)

Work Telephone: ( ) - (Area Code / Number)

Screening ID #	Acrostic	Date of Interview	Staff ID #
		/ /	

INITIAL SCREENING INTERVIEW

2. What is your birthdate?

Month / Day / Year

2a. ***Interviewer Only:*** Will the screenee be 35 to 55 years old at randomization?

O Yes O No

INELIGIBLE. Go to Question # **25.**

3. In the <u>past 10 years</u> has a doctor told you that you had cancer?
Do NOT include skin cancer or cancer of the cervix.

O Yes O No O Don't know O Refused

INELIGIBLE. Go to Question # **25.**

4. Have you <u>ever</u> had any radiation therapy to either of your breasts?

O Yes O No O Don't know O Refused

INELIGIBLE. Go to Question # **25.**

5. Have you <u>ever</u> had any surgery, other than a needle biopsy, close to your nipples?

O Yes O No O Don't know O Refused

INELIGIBLE. Go to Question # **25.**

6. Have you <u>ever</u> had any breast implants?

O Yes O No O Don't know O Refused

INELIGIBLE. Go to Question # **25.**

7. Have you <u>ever</u> had a breast biopsy (removal of breast tissue) or needle aspiration (needle inserted into the breast to withdraw fluid)?

O Yes O No O Don't know O Refused

7a. Have you had <u>more than one</u> biopsy?

(Interviewer Note: A biopsy in each breast is considered two biopsies.)

O Yes O No O Don't know

8. Are you currently taking any anti-tumor medications or medications to prevent breast cancer, such as tamoxifen or raloxifene?

O Yes O No O Don't know O Refused

INELIGIBLE. Go to Question # **25.**

9. In the <u>past 6 months</u>, have you had regular menstrual periods (do NOT include bleeding due to taking female hormone pills)?

O Yes O No O Don't know O Refused

INELIGIBLE. Go to Question # **25.**

10. How old were you at the time of your first menstrual period?
If you are unsure, please make your best guess.

☐☐ years old O Don't know O Refused

11. Now please think about the past 3 months. In the <u>past three months</u>, have you used any oral contraceptives (birth control pills) for any reason, such as contraception, acne, or menstrual irregularities?

O Yes O No O Don't know O Refused

INELIGIBLE. Go to Question # **25.**

12. Have you been pregnant in the <u>past 6 months</u>?

Interviewer Note: This includes women who are currently pregnant.

O Yes O No O Don't know O Refused

INELIGIBLE. Go to Question # **25.**

Screening ID #	Acrostic	Date of Interview	Staff ID #
		/ /	

INITIAL SCREENING INTERVIEW

13. Have you ever been pregnant?

O Yes O No O Don't know O Refused

13a. How many of your pregnancies resulted in the birth of a live child?
(Interviewer Note: If "0", go to Question #15.)

☐☐ pregnancies O Don't know

13b. How old were you when your first child was born?

☐☐ years old O Don't know

14. In the past 6 months, have you breast-fed a child?

O Yes O No O Don't know O Refused

INELIGIBLE. Go to Question # **25.**

15. What is your ethnic background?

O Asian
O Black/African American
O Hawaiian/ Other Pacific Islander
O Hispanic or Latino
O Native American
O White/Caucasian
O Other ***(Please specify:*** _____)
O Refused

16. Was your natural mother (the one that gave birth to you) ever diagnosed with breast cancer?

O Yes O No O Don't know O Refused

17. Do you have any living and/or deceased FULL SISTERS (same mother and father as you)?

O Yes O No O Don't know O Refused

Go to Question #**18.**

17a. Have any of your FULL SISTERS ever been diagnosed with breast cancer?

O Yes O No O Don't know

Go to Question #**18.**

i.) How many of your FULL SISTERS had breast cancer?

☐☐ full sisters O Don't know

18. Do you have any living and/or deceased DAUGHTERS?
(Do NOT include step-daughters or daughters who are not blood relatives.)

O Yes O No O Don't know O Refused

Go to Question #19.

18a. How many DAUGHTERS do you have?

I have ☐☐ daughters O Don't know

18b. Have any of your DAUGHTERS ever been diagnosed with breast cancer?

O Yes O No O Don't know

Go to Question #19.

i.) How many of your DAUGHTERS had breast cancer?

☐☐ daughters had breast cancer O Don't know

19. Has a doctor ever told you that you have deep vein thrombosis (DVT) or blood clots?

O Yes O No O Don't know O Refused

INELIGIBLE. Go to Question # **25.**

20. Has a doctor ever told you that you have irritable bowel syndrome (IBS)?

O Yes O No O Don't know O Refused

INELIGIBLE. Go to Question # **25.**

INELIGIBLE. Go to Question # **25.**

20a. Have you had recurrent episodes of diarrhea and/or constipation in the last 12 months?

O Yes O No O Don't know O Refused

INELIGIBLE. Go to Question # **25.**

Screening ID #	Acrostic	Date of Interview	Staff ID #
		/ /	

INITIAL SCREENING INTERVIEW

21. Do you eat soy foods, such as tofu, miso, soy milk, soy beans, soy flour, or soy protein, more than once a week?

O Yes O No O Don't know O Refused

INELIGIBLE. Go to Question # **25.**

21a. Would you be willing to stop eating soy foods for three months to participate in this study?

O Yes O No O Don't know O Refused

INELIGIBLE. Go to Question # **25.**

22. Are you currently taking any dietary supplements or herbs containing soy or isoflavones, such as Estroven, One-a-Day Bone Strength, Promensil or other supplements containing "soy" or "red clover"?

O Yes O No O Don't know O Refused

INELIGIBLE. Go to Question # **25.**

22a. Would you be willing to stop taking the supplements for three months to participate in this study?

O Yes O No O Don't know O Refused

INELIGIBLE. Go to Question # **25.**

23. In the past 30 days have you been involved in any other medical research study involving an investigational drug?

O Yes O No O Don't know O Refused

INELIGIBLE. Go to Question # **25.**

24. ***Interviewer Note: Calculate 5-year Gail Risk and record below:***

. %

Is this value greater than or equal to 1.66%?

O Yes O No O Don't know

INELIGIBLE. Go to Question # **25.**

25. ***Interviewer Note: Do not read.***

Is the participant eligible to continue screening for the study?

○ Yes

INTERVIEWER NOTE: IF SCREENEE IS <u>ELIGIBLE</u> READ THE FOLLOWING SCRIPT

Thank you for your answers. From the information you have just given me, it is very likely that you are eligible to participate in this study. The next step is for us to schedule a time for you to come to the clinic for an exam. We will be performing a series of tests and asking you some more detailed medical history questions at your screening visit, to ensure that you are eligible. This clinic visit may take up to 3 hours. This visit needs to take place during days 7-13 of your menstrual cycle.

What date and time of the day is most convenient for you? ***(Check available dates and times.)***

I will call you back to schedule the appointment with you.

Do you have any questions? Please feel free to call me at ( )_____-_____ if any questions should come up.

That's about all the information I need at this time. I'd like to thank you for taking the time to talk to me. I look forward to meeting with you.

○ No

INTERVIEWER NOTE: IF SCREENEE IS <u>INELIGIBLE</u> READ THE FOLLOWING SCRIPT

Thank you very much for this information. It will be very useful in the study. Only a limited number of people are being selected to come to the clinical part of the study. At this time you are not eligible to participate in the study, but we greatly appreciate your time and effort in answering questions for us.

I would like to thank you for taking the time to talk to me. If you have any questions, please feel free to call me at ( )_____-_____.

Interviewer Note: Go to Page 1 and complete the Participant Status section.

PREVENT

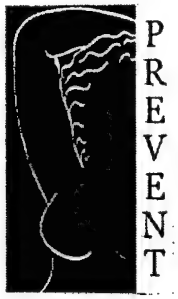
Screening ID #	Acrostic	Date of Interview	Staff ID #
		Month / Day / Year	

SCREENING VISIT CHECKLIST

Checklist Items	Please check if completed			Comments
	Yes	No, participant refused	No, other reason	
1. Informed consent	O	O	O	
2. Medical History	O	O	O	
3. Menstrual History	O	O	O	
4. Anthropometrics	O	O	O	
5. Vital Signs	O	O	O	
6. Physical Exam	O	O	O	
7. Blood Draw	O	O	O	
8. Mammogram	O	O	O	
9. Dispense Run-in	O	O	O	

Participant Status

- O Eligible to continue, randomization visit scheduled
- O Eligible, but not interested or refused to schedule randomization visit
- O Not eligible
- O Not eligible, refused screening visit interview



Screening ID #	Acrostic	Date of Interview	Staff ID #
		Month / Day / Year	

MEDICAL HISTORY

Past Medical History

Please indicate any significant illnesses which apply to participant:

1.	Angina (chest pain)	O Yes O No	8.	Deep vein thrombosis	O Yes O No
2.	Atrial fibrillation	O Yes O No	9.	Transient ischemic attack (TIA)	O Yes O No
3.	Heart attack	O Yes O No	10.	Depression	O Yes O No
4.	Heart failure	O Yes O No	11.	Nervous or emotional disorder	O Yes O No
5.	High blood pressure (hypertension)	O Yes O No	12.	Psychiatric problems	O Yes O No
5a.	If YES, is the hypertension currently controlled?	O Yes O No	13.	Liver disease, yellow jaundice, hepatitis, cirrhosis	O Yes O No
6.	Stroke	O Yes O No	14.	Superficial phlebitis	O Yes O No
7.	Pulmonary embolism	O Yes O No			

15. Other major illnesses (please describe): _____

_____

_____

_____

Screening ID #	Acrostic	Date of Interview	Staff ID #
		Month / Day / Year	

MEDICAL HISTORY (cont.)

Medication History

Please indicate below which of the medications the participant is currently taking or has taken. If the participant has never taken the medication, select both "No" bubbles. If the participant has ever taken the medication in the past, select the appropriate "Yes" bubble. For "Yes" answers, please record the date of the last dose.

	Medications	Currently Taking	Previously Taken	Date Last Taken
16.	Antidepressants (Prozac, Elavil, etc.)	O Yes O No	O Yes O No	/
17.	Antiestrogen (Tamoxifen, etc.)	O Yes O No	O Yes O No	/
17a.	If "YES", what was the duration of therapy	months		
18.	Selective estrogen receptor modulator (Raloxifene)	O Yes O No	O Yes O No	/
18a.	If "YES", what was the duration of therapy	months		
19.	Blood thinners (Coumadin, Dicumarol, etc.)	O Yes O No	O Yes O No	/
20.	Diethylstibestol	O Yes O No	O Yes O No	/
21.	Estrogen (oral estrogen or vaginal creams)	O Yes O No	O Yes O No	/
22.	Oral contraceptives (birth control pills)	O Yes O No	O Yes O No	/
23.	Progesterone	O Yes O No	O Yes O No	/
24.	Other hormone, specify	O Yes O No	O Yes O No	/
25.	Investigational drug(s)	O Yes O No	O Yes O No	/

(please specify): _____

_____

_____

_____

PREVENT

Screening ID #	Acrostic	Date of Interview	Staff ID #
		Month / Day / Year	

SMOKING AND ALCOHOL HISTORY

Smoking/Alcohol History:

26. Have you smoked at least 100 cigarettes (5 packs) in your entire life?

O Yes O No → Skip to Question #30.

27. How old were you when you first started smoking regularly? ☐☐☐ years old.

28. On the average of the entire time you smoked, how many cigarettes did you smoke per day? ☐☐☐ cigarettes

29. Do you smoke cigarettes now?

O Yes

About how many cigarettes do you smoke per day? ☐☐☐ cigarettes

O No

How old were you when you stopped smoking? ☐☐☐ years old

30. Have you ever, or do you currently drink alcohol?

O Yes, but only in the past O Yes, currently O No, never

30a. If yes, on average, how many alcoholic beverages (i.e. beer, wine, mixed drinks, etc.) do you currently consume weekly?

- O None
- O Less than 1 drink per week
- O 1-4 drinks per week
- O 5-9 drinks per weeks
- O 10-19 drinks per week
- O more than 19 drinks per week

Screening ID #	Acrostic	Date of Interview	Staff ID #
		Month / Day / Year	

CONTACT INFORMATION

31. Please provide the name and address of one person who can always reach you.

First Name

Last Name

Street Address

Apt/Room

City

State

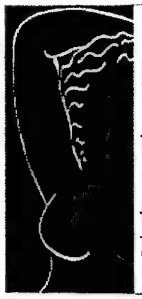
Zip Code

Home Telephone: ( ) -

Area Code Number

Work Telephone: ( ) -

Area Code Number



Screening ID #	Acrostic	Date of Interview	Staff ID #
		Month / Day / Year	

MENSTRUAL HISTORY

1. In the <u>past 6 months,</u> have you had regular menstrual periods (do NOT include bleeding due to taking female hormone pills)?

O Yes O No O Don't know O Refused

2. Date of onset of last menstrual period? Month / Day / Year

3. How old were you at the time of your first menstrual period? If you are unsure, please make your best guess.

years old O Don't know O Refused

4. Now please think about the past 3 months. In the past three months, have you used any oral contraceptives (birth control pills) for any reason, such as contraception, acne, menstrual irregularities, etc.)?

O Yes O No O Don't know O Refused

5. Have you ever had a hysterectomy (surgery to remove your uterus or womb)?

O Yes O No O Don't know O Refused

5a. If you had a hysterectomy, how old were you when you had this surgery?

years old

6. Have you ever had an oophorectomy (removal of an ovary)?

O Yes O No O Don't know O Refused

6a. If you had an oophorectomy, what was the type?

O Unilateral O Bilateral O Unknown

6b. If you had an ophorectomy, what was the date? Month / Year

Screening ID #	Acrostic	Date of Interview	Staff ID #
		Month / Day / Year	

ANTHROPOMETRY

Visit: O Screening Visit O 6 Month Visit (Closeout)

STANDING HEIGHT

. cm

Staff ID#:

WEIGHT

. kg

Staff ID#:

Screening ID #	Acrostic	Date of Interview	Staff ID #
		Month / Day / Year	

VITAL SIGNS

Visit: O Screening Visit O 6 Month Visit (Close Out)

BLOOD PRESSURE

Staff ID#

a. **Cuff Size** O Small O Regular O Large

b. **Arm Used** O Right O Left

***Examiner Note: If possible, use same arm as in previous visit**

BLOOD PRESSURE

Sitting Blood Pressure Measurement

c. **Systolic** mmHg

d. **Diastolic** mmHg

RADIAL PULSE

Staff ID#

beats per minute

Screening ID #	Acrostic	Date of Interview	Staff ID #
		Month / Day / Year	

PHYSICAL EXAMINATION

Visit: O Screening Visit O 6 Month Visit (Closeout)

1. Examinations		Describe Abnormalities
Eyes, Ears, Nose, Throat	O Normal O Abnormal O Not done	
Head, Neck (including thyroid)	O Normal O Abnormal O Not done	
Heart	O Normal O Abnormal O Not done	
Lungs	O Normal O Abnormal O Not done	
Abdomen (liver, kidney, spleen, gastrointestinal)	O Normal O Abnormal O Not done	
Lymph Nodes	O Normal O Abnormal O Not done	
Skin	O Normal O Abnormal O Not done	
Musculoskeletal (extremities/spine)	O Normal O Abnormal O Not done	
Neurological	O Normal O Abnormal O Not done	
General appearance	O Normal O Abnormal O Not done	
Pelvic	O Normal O Abnormal O Not done	
Breast Exam Score:	O I O II O III O IV O V	
I-involutional II=fibrocystic III=mass/repeat exam 3-6 mos or sono IV=suspicious;needs bx V=frank cancer		

If abnormal findings are clinically significant (at PI's discretion), fill out the Adverse Events form and refer for appropriate follow-up treatment.

PREVENT

Screening ID #	Acrostic	Date of Interview	Staff ID #
		Month / Day / Year	

BLOOD DRAW

Visit: O Screening Visit O 6 Month Visit (Close Out)

1. Was any blood drawn?

O Yes O No

Please describe why not?

_____

_____

2. Were tubes filled to specified capacity? If not, comment why.

	Vol.	YES	NO	
1. Serum	10 ml	O	O→	_____
2. Serum	10 ml	O	O→	_____
3. Serum	10 ml	O	O→	_____
4. EDTA Plasma	10 ml	O	O→	_____
5. SST	10 ml	O	O→	_____
6. SST	10 ml	O	O→	_____
7. SST	10 ml	O	O→	_____

Screening ID #	Acrostic	Date of Interview	Staff ID #
		Month / Day / Year	

STUDY DRUG PLACEBO DISPENSATION for RUN-IN

1. A one month's supply (35 packages) of soy/placebo has been dispensed to participant? O Yes O No

2. Soy/Placebo Package #: ☐☐☐

3. A one month's supply of tamoxifen/placebo (35 pills) have been dispensed to participant? O Yes O No

4. Tamoxifen/Placebo Pill Bottle #: ☐☐☐

5. Was the 24 hour urine collection kit dispensed? O Yes O No

PREVENT

Screening ID #	Acrostic	Date of Interview	Staff ID #
		Month / Day / Year	

RANDOMIZATION VISIT CHECKLIST

NOTE: This visit must take place only on days 7-12 of the patient's menstrual cycle.

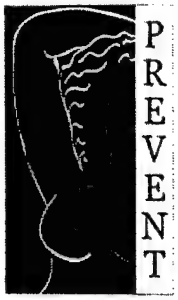
Checklist Items	Please check if completed			Comments
	Yes	No, participant refused	No, other reason or N/A	
1. Run-in Compliance	O	O	O	
2. Medication Inventory	O	O	O	
3. Symptom Checklist	O	O	O	
4. CES-D	O	O	O	
5. 24 Hour Urine	O	O	O	
6. Nipple Aspiration Lavage	O	O	O	
7. Final Eligibility	O	O	O	
8. Randomization	O	O	O	

Participant Status

O Eligible to continue, randomize and dispense pills/packets

O Eligible, but not interested

O Not eligible



Screening ID #	Acrostic	Date of Interview	Staff ID #
		Month / Day / Year	

RUN-IN COMPLIANCE

Note: The participant should take today's dosage before this form is completed.

Date of Screening Visit: Month / Day / Year

Number of days since Screening Visit:

Number of tablets remaining: Number of packets remaining:

Find the row corresponding to the number of days since the screening visit. If the number of tablets that the participant has left is less than or equal to the number in the corresponding row in the table, then they are eligible for randomization (compliance > 80%).

Days Since Screening Visit	Maximum Number of Tablets Remaining	Maximum Number of Packets Remaining
25	20	20
26	21	21
27	22	22
28	23	23
29	23	23
30	24	24
31	25	25
32	26	26
33	26	26
34	27	27
35	28	28

Eligibility:

≥ 80% compliance tablets	≥ 80% compliance packets
○ Yes ○ No → **Ineligible**	○ Yes ○ No → **Ineligible**

Screening ID #	Acrostic	Date of Interview	Staff ID #
		Month / Day / Year	

MEDICATION INVENTORY

Please record medications the participant is currently taking including over the counter medications.

A. Medication

Date Started Month / Day / Year

B. Medication

Date Started Month / Day / Year

C. Medication

Date Started Month / Day / Year

D. Medication

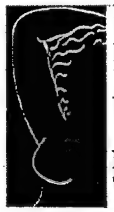
Date Started Month / Day / Year

E. Medication

Date Started Month / Day / Year

F. Medication

Date Started Month / Day / Year



PREVENT

Screening ID #	Acrostic	Date of Interview	Staff ID #
		/ /	

MEDICATION INVENTORY (cont'd)

Please record medications the participant is currently taking including over the counter medications.

G. **Medication**

Date Started Month / Day / Year

H. **Medication**

Date Started Month / Day / Year

I. **Medication**

Date Started Month / Day / Year

J. **Medication**

Date Started Month / Day / Year

K. **Medication**

Date Started Month / Day / Year

L. **Medication**

Date Started Month / Day / Year

PREVENT

Screening ID #	Acrostic	Date of Interview	Staff ID #
		Month / Day / Year	

SYMPTOM CHECKLIST

Visit: O Randomization O 3 Month Visit O 6 Month Visit (Closeout)

Dear Participant: Please fill out this form and return it to a PREVENT staff member. If you have any questions about how to answer the items on this form, please ask for help. All of the information collected on this form will be kept strictly confidential and will be used only for research purposes. If you feel uncomfortable about answering any of these questions, please leave the item blank. Your answers to these questions will not affect your continued participation in this study.

What was the date of the first day of your last menstrual period? Month / Day / Year

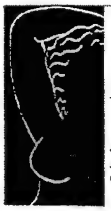
We are interested in knowing the extent to which you have been bothered by any of the following problems during the **PAST FOUR WEEKS**. Please SELECT the appropriate number, using the following code:

0 - Not at all 1 - Slightly 2 - Moderately 3 - Quite a bit 4 - Extremely

	Symptom Problem	How much have you been bothered in the past 4 weeks? 0	1	2	3	4
1.	Hot flashes	O	O	O	O	O
2.	Night sweats	O	O	O	O	O
3.	Cold sweats	O	O	O	O	O
4.	Constipation	O	O	O	O	O
5.	Vaginal discharge	O	O	O	O	O
6.	Vaginal bleeding or spotting	O	O	O	O	O
7.	Genital itching/irritation	O	O	O	O	O
8.	Vaginal dryness	O	O	O	O	O
9.	Pain with intercourse	O	O	O	O	O
10.	Dry mouth	O	O	O	O	O

	Symptom Problem	How much have you been bothered in the past 4 weeks? 0	1	2	3	4
11.	Weight loss	O	O	O	O	O
12.	Decreased appetite	O	O	O	O	O
13.	Abdominal cramps	O	O	O	O	O
14.	Leg cramps	O	O	O	O	O
15.	Difficulty with bladder control (when laughing or crying)	O	O	O	O	O
16.	Difficulty with bladder control (at other times)	O	O	O	O	O
17.	Weight gain	O	O	O	O	O
18.	Forgetfullness	O	O	O	O	O
19.	I felt that people disliked me.	O	O	O	O	O
20.	I could not get going.	O	O	O	O	O

Signature of Person Completing Form



Screening ID #	Acrostic	Date of Interview	Staff ID #
		/ /	

SYMPTOM CHECKLIST (cont'd)

We are interested in knowing the extent to which you have been bothered by any of the following problems during the **PAST FOUR WEEKS**. Please SELECT the appropriate number, using the following code:

0 - Not at all 1 - Slightly 2 - Moderately 3 - Quite a bit 4 - Extremely

	Symptom Problem	How much have you been bothered in the past 4 weeks? 0	1	2	3	4
21.	Chest pains	O	O	O	O	O
22.	Fever	O	O	O	O	O
23.	Nausea	O	O	O	O	O
24.	Upset stomach or indigestion	O	O	O	O	O
25.	Vomiting	O	O	O	O	O
26.	Intestinal gas (flatulence)	O	O	O	O	O
27.	Sinus problems	O	O	O	O	O
28.	Coughing	O	O	O	O	O
29.	Skin rash	O	O	O	O	O

	Symptom Problem	How much have you been bothered in the past 4 weeks? 0	1	2	3	4
30.	Insomnia	O	O	O	O	O
31.	Depression	O	O	O	O	O
32.	Headaches	O	O	O	O	O
33.	Breast sensitivity/tenderness	O	O	O	O	O
34.	General aches and pains	O	O	O	O	O
35.	Joint pains	O	O	O	O	O
36.	Swelling of hands or feet	O	O	O	O	O
37.	Muscle stiffness	O	O	O	O	O
38.	Early awakening	O	O	O	O	O

Signature of Person Completing Form

PREVENT

Screening ID #	Acrostic	Date of Interview	Staff ID #
		Month / Day / Year	

CES-D

Visit: O Randomization O 6 Month Visit (Closeout)

For each of the following statements, please tell me if you felt that way: Rarely, or none of the time; some of the time; much of the time; or, most or all of the time

During the past week . . .	Rarely or none of the time (< 1 day)	Some of the time (1-2 days)	Much of the time (3-4 days)	Most or all of the time (5-7 days)	Don't Know	Refused
1. I was bothered by things that usually don't bother me.	O	O	O	O	O	O
2. I did not feel like eating; my appetite was poor.	O	O	O	O	O	O
3. I felt that I could not shake off the blues even with the help of my family or friends.	O	O	O	O	O	O
4. I felt that I was just as good as other people.	O	O	O	O	O	O
5. I had trouble keeping my mind on what I was doing.	O	O	O	O	O	O
6. I felt depressed.	O	O	O	O	O	O
7. I felt that everything I did was an effort.	O	O	O	O	O	O
8. I felt hopeful about the future.	O	O	O	O	O	O
9. I thought my life had been a failure.	O	O	O	O	O	O
10. I felt fearful.	O	O	O	O	O	O
11. My sleep was restless.	O	O	O	O	O	O
12. I was happy.	O	O	O	O	O	O
13. I talked less than usual.	O	O	O	O	O	O
14. I felt lonely.	O	O	O	O	O	O
15. People were unfriendly.	O	O	O	O	O	O
16. I enjoyed life.	O	O	O	O	O	O
17. I had crying spells.	O	O	O	O	O	O
18. I felt sad.	O	O	O	O	O	O
19. I felt that people disliked me.	O	O	O	O	O	O
20. I could not get going.	O	O	O	O	O	O

Screening ID #	Acrostic	Date of Interview	Staff ID #
		Month / Day / Year	

24 HOUR URINE COLLECTION AND PROCESSING

Visit: O Randomization Visit O 6 Month Visit (Closeout)

1. Was the 24 hour urine collected? O Yes O No

Describe any problems:

_____

_____

_____

_____

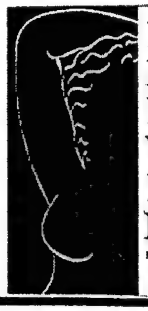
Interviewer Note: Urine collection should be sent for processing to Core Lab.

2. Record the volume of urine (in CC): ____ ccs

3. Record the creatinine results: ____ mg/kg/day

4. Note location of banking: _____

Interviewer Note: Samples should be banked at -20 C and sent to Dept. of Food Science and Nutrition, University of Minnesota, 1334 Eckles Ave., St. Paul, MN 55105 at closeout.



PREVENT

Screening ID #	Acrostic	Date of Interview	Staff ID #
		Month / Day / Year	

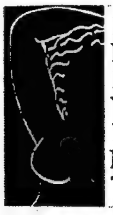
NIPPLE ASPIRATION AND DUCTAL LAVAGE

Visit: O Randomization O 6 Month Visit (Closeout)

AFFIX LABEL

RIGHT BREAST - Nipple Aspiration		
1. Was Nipple Aspiration attempted?	O Yes	O No
2. Was fluid elicited?	O Yes	O No
3. Identify each duct yeilding fluid?	O Yes	O No
4. Color of fluid? O Clear O White O Yellow O Red O Green O Brown O Black O Other		

RIGHT BREAST - Ductal Lavage		
1. Was Ductal Lavage attempted?	O Yes	O No
2. Number of ducts with Nipple Aspirate Fluid?	O 1 O 2 O 3	
3. Duct ID#?		
4. Saline volume infused/returned in ml?	ml	ml



Screening ID #	Acrostic	Date of Interview	Staff ID #
		/ /	

NIPPLE ASPIRATION AND DUCTAL LAVAGE (cont.)

LEFT BREAST - Nipple Aspiration		
1. Was Nipple Aspiration attempted?	O Yes	O No
2. Was fluid elicited?	O Yes	O No
3. Identify each duct yeilding fluid?	O Yes	O No
4. Color of fluid? O Clear O White O Yellow O Red O Green O Brown O Black O Other		

LEFT BREAST - Ductal Lavage		
1. Was Ductal Lavage attempted?	O Yes	O No
2. Number of ducts with Nipple Aspirate Fluid?	O 1 O 2 O 3	
3. Duct ID#?		
4. Saline volume infused/returned in ml?	ml	ml

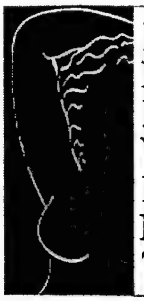
Screening ID #	Acrostic	Date of Interview	Staff ID #
		Month / Day / Year	

FINAL ELIGIBILITY

Eligibility Criteria: All answers to the following questions should be YES.

	Meets Eligibility Criteria
1. Signed Consent Forms	O Yes O No
2. Pre-menopausal, not on hormones	O Yes O No
3. Mammogram >50% density	O Yes O No
4. Clinical labs within acceptable range	O Yes O No
5. Gail Risk >1.66 OR BRCA2 mutation	O Yes O No
6. History and Physical Exam (includes Clinical Breast Exam)	O Yes O No
7. Baseline urine and blood collection	O Yes O No
8. Ductal Lavage attempted (sample collected)	O Yes O No
9. Pregnancy test negative	O Yes O No
10. NOT had highly irregular menstrual cycle unless FSH, LH and estradiol are in the pre-menopausal normal range	O Yes O No
11. Agreed NOT to consume soy protein more than one time per week during the study period	O Yes O No
12. NOT had bilateral or unilateral prophylactic mastectomy	O Yes O No
13. NOT involved in another cancer prevention study	O Yes O No
14. NOT had active infections or inflammation in either breast	O Yes O No

Interviewer Note: If participant is eligible to continue, proceed to randomization.



PREVENT

Screening ID #	Acrostic	Date of Interview	Staff ID #
		Month / Day / Year	

RANDOMIZATION

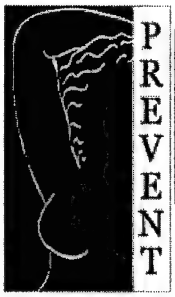
Date Randomized: Month / Day / Year

Randomization #:

The Information Contained In This Randomization Section Is Accurate And Complete.

Principal Investigator

Date



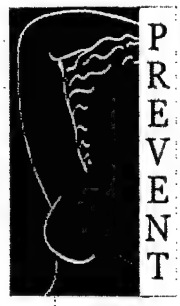
Screening ID #	Acrostic	Date of Interview	Staff ID #
		Month / Day / Year	

STUDY DRUG DISPENSATION

1. A three month's supply of study pills/packets has been dispensed to participant? O Yes O No

2. Package #: ☐☐☐

3. Was the 24 hour urine collection kit dispensed? O Yes O No



Screening ID #	Acrostic	Date of Interview	Staff ID #
		Month / Day / Year	

TELEPHONE FOLLOW-UP CHECKLIST

Visit: O 3 day O 30 day

Checklist Items	Please check if completed			Comments
	Yes	No, participant refused	No, other reason	
1. Compliance Assessment	O	O	O	

Participant Status

- O Participant contacted, follow-up completed
- O Participant contacted, left message
- O Refused to complete follow-up
- O Call back ⟶ Date: _____

Screening ID #	Acrostic	Date of Interview	Staff ID #
		Month / Day / Year	

TELEPHONE COMPLIANCE ASSESSMENT

Visit: O 3 day O 30 day

1. Are you currently taking the soy/placebo protein? O Yes O No

2. Since our last contact, how many days have you NOT taken your protein? ☐☐☐

3. Are you currently taking the tamoxifen/placebo pills? O Yes O No

4. Since our last contact, how many days have you NOT taken your pills? ☐☐☐

Screening ID #	Acrostic	Date of Interview	Staff ID #
		Month / Day / Year	

3 MONTH FOLLOW-UP VISIT CHECKLIST

Checklist Items	Please check if completed			Comments
	Yes	No, participant refused	No, other reason	
1. Adverse Event	O	O	O	
2. Compliance	O	O	O	
3. Medication Update	O	O	O	
4. Symptom Checklist	O	O	O	
5. Dispense Therapy	O	O	O	

Participant Status

O Eligible to continue, dispense pills/packets

O Not eligible

PREVENT

Screening ID #	Acrostic	Date of Interview	Staff ID #
		Month / Day / Year	

MEDICATION INVENTORY FOLLOW-UP

Visit: O 3 Month Follow-up Visit O 6 Month Follow-up Visit (Closeout)

1. ***Examiner say: Have you taken any medications or supplements since your last clinic visit?***

O Yes O No → Go to question 3.

2. ***Examiner: Are any of the participant's medications/supplements listed under the exclusion criteria in the protocol?***

O Yes O No → Go to question 3.

Record medications below ONLY if they are listed on the "PREVENT Exclusionary/Concomitant Medications Listing" and if they have not been recorded at a previous visit. EXCEPTION: If a medication has been previously recorded and was stopped/restarted OR the dose was changed, list the medication below. **Please record by brand name, if known.**

A. Medication

Reason for use

Date Started / / **Date Stopped** / / O Ongoing

B. Medication

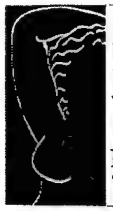
Reason for use

Date Started / / **Date Stopped** / / O Ongoing

C. Medication

Reason for use

Date Started / / **Date Stopped** / / O Ongoing



Screening ID #	Acrostic	Date of Interview	Staff ID #
		/ /	

MEDICATION INVENTORY FOLLOW-UP (cont'd)

D. Medication

Reason for use

Date Started / / Date Stopped / / O Ongoing

E. Medication

Reason for use

Date Started / / Date Stopped / / O Ongoing

F. Medication

Reason for use

Date Started / / Date Stopped / / O Ongoing

G. Medication

Reason for use

Date Started / / Date Stopped / / O Ongoing

H. Medication

Reason for use

Date Started / / Date Stopped / / O Ongoing

3. Examiner: Has the participant stopped or changed the dose of any concomitant meds reported on previous visits?

O Yes O No

Screening ID #	Acrostic	Date of Interview	Staff ID #
		Month / Day / Year	

SYMPTOM CHECKLIST

Visit: O Randomization O 3 Month Visit O 6 Month Visit (Closeout)

Dear Participant: Please fill out this form and return it to a PREVENT staff member. If you have any questions about how to answer the items on this form, please ask for help. All of the information collected on this form will be kept strictly confidential and will be used only for research purposes. If you feel uncomfortable about answering any of these questions, please leave the item blank. Your answers to these questions will not affect your continued participation in this study.

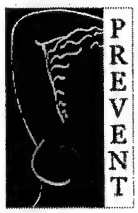
What was the date of the first day of your last menstrual period? Month / Day / Year

We are interested in knowing the extent to which you have been bothered by any of the following problems during the **PAST FOUR WEEKS**. Please SELECT the appropriate number, using the following code:

0 - Not at all 1 - Slightly 2 - Moderately 3 - Quite a bit 4 - Extremely

	Symptom Problem	How much have you been bothered in the past 4 weeks? 0	1	2	3	4
1.	Hot flashes	O	O	O	O	O
2.	Night sweats	O	O	O	O	O
3.	Cold sweats	O	O	O	O	O
4.	Constipation	O	O	O	O	O
5.	Vaginal discharge	O	O	O	O	O
6.	Vaginal bleeding or spotting	O	O	O	O	O
7.	Genital itching/irritation	O	O	O	O	O
8.	Vaginal dryness	O	O	O	O	O
9.	Pain with intercourse	O	O	O	O	O
10.	Dry mouth	O	O	O	O	O
11.	Weight loss	O	O	O	O	O
12.	Decreased appetite	O	O	O	O	O
13	Abdominal cramps	O	O	O	O	O
14.	Leg cramps	O	O	O	O	O
15.	Difficulty with bladder control (when laughing or crying)	O	O	O	O	O
16.	Difficulty with bladder control (at other times)	O	O	O	O	O
17.	Weight gain	O	O	O	O	O
18.	Forgetfullness	O	O	O	O	O
19.	I felt that people disliked me.	O	O	O	O	O
20.	I could not get going.	O	O	O	O	O

Signature of Person Completing Form



Screening ID #	Acrostic	Date of Interview	Staff ID #
		/ /	

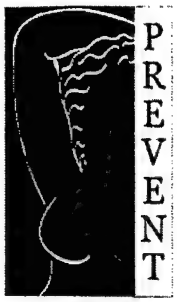
SYMPTOM CHECKLIST (cont'd)

We are interested in knowing the extent to which you have been bothered by any of the following problems during the **PAST FOUR WEEKS**. Please SELECT the appropriate number, using the following code:

0 - Not at all 1 - Slightly 2 - Moderately 3 - Quite a bit 4 - Extremely

	Symptom Problem	How much have you been bothered in the past 4 weeks? 0	1	2	3	4		Symptom Problem	How much have you been bothered in the past 4 weeks? 0	1	2	3	4
21.	Chest pains	O	O	O	O	O	30.	Insomnia	O	O	O	O	O
22.	Fever	O	O	O	O	O	31.	Depression	O	O	O	O	O
23.	Nausea	O	O	O	O	O	32.	Headaches	O	O	O	O	O
24.	Upset stomach or indigestion	O	O	O	O	O	33.	Breast sensitivity/tenderness	O	O	O	O	O
25.	Vomiting	O	O	O	O	O	34.	General aches and pains	O	O	O	O	O
26.	Intestinal gas (flatulence)	O	O	O	O	O	35.	Joint pains	O	O	O	O	O
27.	Sinus problems	O	O	O	O	O	36.	Swelling of hands or feet	O	O	O	O	O
28.	Coughing	O	O	O	O	O	37.	Muscle stiffness	O	O	O	O	O
29.	Skin rash	O	O	O	O	O	38.	Early awakening	O	O	O	O	O

Signature of Person Completing Form



Screening ID #	Acrostic	Date of Interview	Staff ID #
		Month / Day / Year	

COMPLIANCE ASSESSMENT

Visit: O 3 Month Follow-up Visit O 6 Month Follow-up Visit (Closeout)

Note: The participant should take today's dosage before this form is completed.

Number of tablets remaining (by pill count): ☐☐☐

Number of packets remaining (by packet count): ☐☐☐

Screening ID #	Acrostic	Date of Interview	Staff ID #
		Month / Day / Year	

STUDY DRUG DISPENSATION

1. A three month's supply of study pills/packets has been dispensed to participant? O Yes O No

2. Package #:

3. Was the 24 hour urine collection kit dispensed? O Yes O No

Screening ID #	Acrostic	Date of Interview	Staff ID #
		Month / Day / Year	

6 MONTH FOLLOW-UP VISIT CHECKLIST

Checklist Items	Please check if completed			Comments
	Yes	No, participant refused	No, other reason	
1. Adverse Event	O	O	O	
2. Compliance	O	O	O	
3. Medication Update	O	O	O	
4. Symptom Checklist	O	O	O	
5. CES-D	O	O	O	
6. Anthropometrics	O	O	O	
7. Vital Signs	O	O	O	
8. Blood Draw	O	O	O	
9. Physical Exam	O	O	O	
10. 24 Hour Urine Collection	O	O	O	
11. Mammogram	O	O	O	
12. Nipple Aspiration/Ductal Lavage	O	O	O	

Screening ID #	Acrostic	Date of Interview	Staff ID #
		Month / Day / Year	

ADVERSE EVENT

Visit: O 3 Month Follow-up Visit O 6 Month Follow-up Visit (Closeout)

An adverse event (AE) is defined as any illness, sign or symptoms, or unfavorable change in clinical status that has appeared or worsened after start of trial whether or not considered related to the use of test drug.

ADVERSE EVENT:

NCI COMMON TOXICITY GRADE: O 1 - Mild O 2 - Moderate O 3 - Severe O 4 - Life-threatening

SERIOUS: O Yes* O No

AE REPORT DATE (mm/dd/yy): / /

DATE OF ONSET (mm/dd/yy): / /

DATE STOPPED (mm/dd/yy): / / O Continuing

PATTERN: O Every dose O Intermittent O Continuous O Once O Not applicable

STUDY DRUG DOSE CHANGE

No O Reduced dose O Dose Interruption (Restarted) O Study drug discontinued**

OTHER ACTION TAKEN BECAUSE OF THIS AE: O Yes O No

IF YES, PLEASE SPECIFY

OUTCOME

O Recovered completely O Recovered with residual effects O Continuing O Fatal* O Unknown

RELATED TO STUDY DRUG

O No O Unlikely O Possible O Probable O Definite

**** Serious = Death, permanent or substantial disability, inpatient hospitalization or prolongation of hospitalization, life-threatening, congenital anomaly, cancer or overdose. Fill Out Serious Adverse Event Form.***

*****If participant discontinued drug, complete Study Drug Discontinuation Visit Forms.***

Principal Investigator's Signature ***Date***

Screening ID #	Acrostic	Date of Interview	Staff ID #
		Month / Day / Year	

ADVERSE EVENT

Visit: O 3 Month Follow-up Visit O 6 Month Follow-up Visit (Closeout)

An adverse event (AE) is defined as any illness, sign or symptoms, or unfavorable change in clinical status that has appeared or worsened after start of trial whether or not considered related to the use of test drug.

ADVERSE EVENT:

NCI COMMON TOXICITY GRADE: O 1 - Mild O 2 - Moderate O 3 - Severe O 4 - Life-threatening

SERIOUS: O Yes* O No

AE REPORT DATE (mm/dd/yy): / /

DATE OF ONSET (mm/dd/yy): / /

DATE STOPPED (mm/dd/yy): / / O Continuing

PATTERN: O Every dose O Intermittent O Continuous O Once O Not applicable

STUDY DRUG DOSE CHANGE

O No O Reduced dose O Dose Interruption (Restarted) O Study drug discontinued**

OTHER ACTION TAKEN BECAUSE OF THIS AE: O Yes O No

IF YES, PLEASE SPECIFY

OUTCOME

O Recovered completely O Recovered with residual effects O Continuing O Fatal* O Unknown

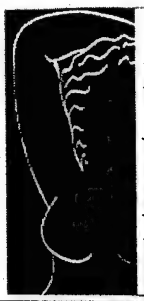
RELATED TO STUDY DRUG

O No O Unlikely O Possible O Probable O Definite

**** Serious = Death, permanent or substantial disability, inpatient hospitalization or prolongation of hospitalization, life-threatening, congenital anomaly, cancer or overdose. Fill Out Serious Adverse Event Form.***

*****If participant discontinued drug, complete Study Drug Discontinuation Visit Forms.***

Principal Investigator's Signature *Date*



PREVENT

Screening ID #	Acrostic	Date of Interview	Staff ID #
		Month / Day / Year	

ADVERSE EVENT

An adverse event (AE) is defined as any illness, sign or symptoms, or unfavorable change in clinical status that has appeared or worsened after start of trial whether or not considered related to the use of test drug.

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***If participant discontinued drug, complete Study Drug Discontinuation Visit Forms.*

Principal Investigator's Signature *Date*

Screening ID #	Acrostic	Date of Interview	Staff ID #
		Month / Day / Year	

DRUG DISCONTINUATION

1. Record the last day the participant took the study tablets/packets: Month / Day / Year

2. What is the main reason the participant decided to stop taking the study tablets/packets? ***(Please check only one major category and one sub-category--if appropriate.)***

O Adverse event

- O Upset stomach
- O Nausea
- O Diarrhea
- O Bloating
- O Hot flashes
- O Other side effects (please specify): _____

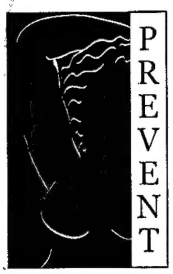
O Participant decision

- O Physician's advice
- O Doesn't like taking medication on a daily basis
- O Family member advice
- O Illness/health problem (non-AE)
- O Does not want to be on placebo
- O Other side (please specify): _____

O Other (Please specify): _____

Appendix B

Informational Tools



Soy / Tamoxifen Study Visit Outline

Questions ? Contact Nicole
(415) 353-9739
nicole.guthrie@ucsfmedctr.org

Please remember all clinic visits must take place between days 7-13 of your menstrual cycle

My target window for visits is days _____ to _____ of the month

Screening Visit (2 hours)
- Sign study consent form
- Mammogram in the MammoVan (parking lot behind Cancer Center)
- Physical exam / Medical History at Breast Care Center (2nd floor)
- Provision of a 1 month supply of Run-in study protein and pills
- Blood draw at Phlebotomy lab (1st floor)

1 month

Randomization Visit (2 hours)
- In the clinic on the 2nd floor
  - Turn in 24 hour urine sample
  - Collection of any remaining Run-in study protein and pills
  - Inventory of current Medication / Review of any symptoms
  - Nipple aspiration / Ductal Lavage
- Randomization and provision of study protein and pills

Telephone Follow-up (15 minutes each)
- They will take place approximately
  - 3 days after Randomization visit
  - 30 days after Randomization visit

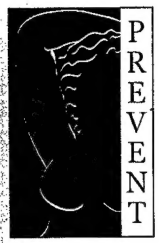
3 months

3 Month Visit (45 minutes)
- A visit with Nicole (6th floor, elevators past the gift shop)
  - Update forms (bring any new medications since Randomization visit)
  - Pick up a new supply of study protein and pills (Pharmacy 5th floor)

3 months

Final Visit, 6 month follow-up (2 hours)
- Blood draw at Phlebotomy lab (1st floor)
- Mammogram in the MammoVan
- In the Breast Care Clinic on the 2nd floor
  - Turn in 24 hour urine sample
  - Physical exam / medical history update
  - Nipple aspiration / Ductal Lavage

THANK YOU for your participation in this important research study



Dietary Guidelines

Please limit your consumption of soy foods through out the entire study

Total consumption of soy foods should be limited to 1 serving a week through out the study

- Listed below are common soy foods. Please, be aware that many prepared and processed foods also contain soy and not all of these foods are listed here. If an item has soy or textured vegetable protein listed in the first 2 ingredients, please limit the frequency that it is consumed.

tofu
tempeh
soy milk
okara
edamame/ soy beans
soy nuts
soy cheese
soy yogurt

***Balance* bars**
***Luna* bars**
Smart Dogs
Morning Star: *Grillers, Chik Patties, Corn Dogs*
***Boca Burgers* and meat replacements**
Veat, all products
Natural Touch Garden Veggie Pattie

- If you are looking for a **soy free** vegetable patty try

Amy's California Veggie Burger
Gardenburger all flavors except the *Hamburger Style*

- The following items **should not be used** through out the length of the study. Please be aware that they may be added to 'energy bars' and some specialty cereals and beverages.

Red Clover: *Trifolium pratense*, meadow clover, purple clover, trefoil

Black Cohosh: *Cimicifuga racemosa*, baneberry, black snakeroot, bugbane, squaw root, rattle root

Chaste tree: *Vitex angus-castus*, Chaste berry

- If you have any questions please contact Nicole by phone at (415) 353-9739 or email at nicole.guthrie@ucsfmedctr.org

University of California
San Francisco

UCSF

**Comprehensive
Cancer Center**

**Carol Franc Buck
Breast Care Center
A Program of the National
Center of Excellence
In Women's Health**

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For non-express mail use:
Box 1710
San Francisco, CA 94143-1710
Tel: 415/353-7070 oncology
Tel: 415/353-7111 surgery
Fax: 415/353-7021

_____ ____, 2002

Dear Dr. _____:

Your patient, _____, date of birth ____-____-____, has enrolled in the PREVENT study at the UCSF Breast Care Center.

The study is being conducted by Jeffrey A. Tice, M.D. and Laura Esserman, M.D., MBA, and associates from the University of California San Francisco. The purpose of the study is to investigate the effects of dietary soy on breast density, nipple aspiration cytology and urinary estrogen metabolites, in comparison to Tamoxifen or placebo.

The study period is a total of 6 months, with a start date the same as the date of this letter. Your patient has agreed for the length of the study period to not use any forms of hormonal or selective estrogen receptor modulator (SERM) therapy.

As part of the study the patient will receive 2 mammograms, one at the start of the study and another at the end of the 6-month period. The results of these measurements, as well as all other tests performed will be available on the patient's request.

If you have any questions or concerns about the participation of your patient in this research project, please feel free to call.

Sincerely;

Nicole Guthrie, MS
Study Coordinator
(415) 353-9739